General Assembly

Amendment

January Session, 2019

LCO No. **8828**

Offered by:
SEN. LOONEY, 11th Dist.
SEN. LESSER, 9th Dist.

To: Senate Bill No. **33** File No. 307 Cal. No. 161

"AN ACT CONCERNING HEALTH INSURANCE COVERAGE OF ORALLY AND INTRAVENOUSLY ADMINISTERED PRESCRIPTION DRUGS."

Strike everything after the enacting clause and substitute the following in lieu thereof:

"Section 1. Subsection (d) of section 38a-504 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2020*):

(d) (1) Each policy of the type specified in subsection (a) of this section **[**that**]** shall:

(A) If such policy provides coverage for intravenously administered and orally administered anticancer medications used to kill or slow the growth of cancerous cells that are prescribed by a prescribing practitioner, as defined in section 20-571, **[**shall**]** provide coverage for orally administered anticancer medications on a basis that is no less

favorable than intravenously administered anticancer medications; and

(B) If such policy provides coverage for intravenously administered and orally administered medications used to treat disabling or life-threatening chronic diseases that are prescribed by a prescribing practitioner, as defined in section 20-571, provide coverage for such orally administered medications on a basis that is no less favorable than such intravenously administered medications if such orally administered medications are approved by the federal Food and Drug Administration for such treatment.

(2) No insurance company, hospital service corporation, medical service corporation, health care center or fraternal benefit society that delivers, issues for delivery, renews, amends or continues in this state a policy of the type specified in subsection (a) of this section shall reclassify **[**such anticancer**]** medications that are subject to subdivision (1) of this subsection or increase the coinsurance, copayment, deductible or other out-of-pocket expense imposed under such policy for such medications to achieve compliance with this subsection.

Sec. 2. Subsection (d) of section 38a-542 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2020*):

(d) (1) Each policy of the type specified in subsection (a) of this section **[**that**]** shall:

(A) If such policy provides coverage for intravenously administered and orally administered anticancer medications used to kill or slow the growth of cancerous cells that are prescribed by a prescribing practitioner, as defined in section 20-571, **[**shall**]** provide coverage for orally administered anticancer medications on a basis that is no less favorable than intravenously administered anticancer medications; and

(B) If such policy provides coverage for intravenously administered

and orally administered medications used to treat disabling or life-threatening chronic diseases that are prescribed by a prescribing practitioner, as defined in section 20-571, provide coverage for such orally administered medications on a basis that is no less favorable than such intravenously administered medications if such orally administered medications are approved by the federal Food and Drug Administration for such treatment.

(2) No insurance company, hospital service corporation, medical service corporation, health care center or fraternal benefit society that delivers, issues for delivery, renews, amends or continues in this state a policy of the type specified in subsection (a) of this section shall reclassify **[**such anticancer**]** medications that are subject to subdivision (1) of this subsection or increase the coinsurance, copayment, deductible or other out-of-pocket expense imposed under such policy for such medications to achieve compliance with this subsection.

Sec. 3. Section 38a-472g of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2020*):

(a) (1) No insurer, health care center, fraternal benefit society, hospital service corporation or medical service corporation or other entity, delivering, issuing for delivery, renewing, amending or continuing an individual or group health insurance policy in this state providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 or utilization review company performing utilization review for such insurer, center, society, corporation or entity, that:

(A) On or after January 1, 2012, issues prior authorization for, or precertifies, **[**on or after January 1, 2012,**]** an admission, service, procedure or extension of stay shall reverse or rescind such prior authorization or precertification or refuse to pay for such admission, service, procedure or extension of stay if:

[(A)**]** (i) Such insurer, center, society, corporation, entity or company failed to notify the insured's or enrollee's health care provider at least

three business days prior to the scheduled date of such admission, service, procedure or extension of stay that such prior authorization or precertification has been reversed or rescinded on the basis of medical necessity, fraud or lack of coverage; and

[(B)**]** (ii) Such admission, service, procedure or extension of stay has taken place in reliance on such prior authorization or precertification; and

(B) On or after January 1, 2020, issues prior authorization for, or precertifies, an admission, service, procedure or extension of stay shall impose any requirement in determining whether to issue prior authorization for, or precertify, an admission, service, procedure or extension of stay if such requirement is unrelated to the determination of whether such admission, service, procedure or extension of stay is medically necessary, as defined in section 38a-482a, as amended by this act, or 38a-513c, as amended by this act, as applicable.

(2) The provisions of this subsection shall apply regardless of whether such prior authorization or precertification is required or is requested by an insured's or enrollee's health care provider. Unless reversed or rescinded as set forth in subparagraph (A)(i) of subdivision (1) of this subsection, such prior authorization or precertification shall be effective for not less than sixty days from the date of issuance.

(b) Nothing in subsection (a) of this section shall be construed to authorize benefits or services in excess of those that are provided for in the insured's or enrollee's policy or contract.

(c) Nothing in subsection (a) of this section shall affect the provisions of subsection (b) of section 38a-479b.

Sec. 4. Section 38a-482a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2020*):

(a) For the purposes of this section:

(1) "Emergency medical condition" has the same meaning as

provided in section 38a-591a;

(2) "Emergency services" has the same meaning as provided in section 38a-591a;

(3) "Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment;

(4) "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease, including, but not limited to, emergency services with respect to an emergency medical condition;

(5) "Medically necessary" or "medical necessity" means health care services that:

(A) A physician, exercising prudent clinical judgment, would provide to a patient, without regard to:

(i) The financial interests of the insurer, health care center, fraternal benefit society, hospital service corporation, medical service corporation or other entity that delivered, issued for delivery, renewed, amended or continued the policy providing coverage for such services;

(ii) Whether such services are provided to the patient by a particular type of licensed health care provider, provided such provider may provide such services within such provider's scope of practice;

(iii) Whether such services are provided to the patient in a particular type of licensed health care facility, provided such services may be provided in such facility in accordance with applicable law; or

(iv) Whether such services are subsequently determined not to be emergency services;

(B) Are in accordance with generally accepted standards of medical practice;

(C) Are clinically appropriate, in terms of type, frequency, extent and duration, and considered effective for a patient's health condition, illness, injury or disease; and

(D) Not provided primarily for the convenience of a patient, physician or another health care provider.

[(a)**]** (b) No insurer, health care center, fraternal benefit society, hospital service corporation, medical service corporation or other entity delivering, issuing for delivery, renewing, continuing or amending any individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 in this state shall: **[**deliver**]**

(1) Deliver or issue for delivery in this state any such policy unless such policy contains **[**a**]** the definition of "medically necessary" or "medical necessity" **[**as follows: "Medically necessary" or "medical necessity" means health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (1) In accordance with generally accepted standards of medical practice; (2) clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and (3) not primarily for the convenience of the patient, physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For the purposes of this subsection, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in

policy issues involving clinical judgment**]** set forth in subsection (a) of this section; or

(2) Deny coverage for health care services solely because such insurer, center, society, corporation or entity retrospectively determines that such services were not medically necessary emergency services.

[(b)**]** (c) The provisions of **[**subsection (a) of**]** this section shall not apply to any insurer, health care center, fraternal benefit society, hospital service corporation, medical service corporation or other entity that has entered into any national settlement agreement until the expiration of any such agreement.

Sec. 5. Section 38a-513c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2020*):

(a) For the purposes of this section:

(1) "Emergency medical condition" has the same meaning as provided in section 38a-591a;

(2) "Emergency services" has the same meaning as provided in section 38a-591a;

(3) "Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment;

(4) "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease, including, but not limited to, emergency services with respect to an emergency medical condition;

(5) "Medically necessary" or "medical necessity" means health care services that:

(A) A physician, exercising prudent clinical judgment, would provide to a patient, without regard to:

(i) The financial interests of the insurer, health care center, fraternal benefit society, hospital service corporation, medical service corporation or other entity that delivered, issued for delivery, renewed, amended or continued the policy providing coverage for such services;

(ii) Whether such services are provided to the patient by a particular type of licensed health care provider, provided such provider may provide such services within such provider's scope of practice;

(iii) Whether such services are provided to the patient in a particular type of licensed health care facility, provided such services may be provided in such facility in accordance with applicable law; or

(iv) Whether such services are subsequently determined not to be emergency services;

(B) Are in accordance with generally accepted standards of medical practice;

(C) Are clinically appropriate, in terms of type, frequency, extent and duration, and considered effective for a patient's health condition, illness, injury or disease; and

(D) Not provided primarily for the convenience of a patient, physician or another health care provider.

[(a)**]** (b) No insurer, health care center, hospital service corporation, medical service corporation or other entity delivering, issuing for delivery, renewing, continuing or amending any group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 in this state shall: **[**deliver**]**

(1) Deliver or issue for delivery in this state any such policy unless

such policy contains **[**a**]** the definition of "medically necessary" or "medical necessity" **[**as follows: "Medically necessary" or "medical necessity" means health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (1) In accordance with generally accepted standards of medical practice; (2) clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and (3) not primarily for the convenience of the patient, physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For the purposes of this subsection, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment**]** set forth in subsection (a) of this section; or

(2) Deny coverage for health care services solely because such insurer, center, society, corporation or entity retrospectively determines that such services were not medically necessary emergency services.

[(b)**]** (c) The provisions of **[**subsection (a) of**]** this section shall not apply to any insurer, health care center, fraternal benefit society, hospital service corporation, medical service corporation or other entity that has entered into any national settlement agreement until the expiration of any such agreement.

Sec. 6. Section 38a-478r of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2020*):

(a) Each provider, as defined in section 38a-478, shall code for the

presenting symptoms of all emergency claims and each hospital shall record such code for such claims on locator 76 on the UB92 form or its successor.

(b) The presenting symptoms, as coded by the provider and recorded by the hospital on the UB92 form or its successor, or the final diagnosis, whichever **[**reasonably**]** indicates an emergency medical condition, as defined in section 38a-591a, shall be the basis for reimbursement or coverage. **[**, provided such symptoms reasonably indicated an emergency medical condition.**]**

[(c) For the purposes of this section, in accordance with the National Committee for Quality Assurance, an emergency medical condition is a condition such that a prudent layperson, acting reasonably, would have believed that emergency medical treatment is needed.**]**

[(d)**]** (c) The **[**Insurance Commissioner**]** commissioner may develop and disseminate to hospitals in this state a claims form system that will ensure that all hospitals consistently code for the presenting and diagnosis symptoms on all emergency claims."

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2020*	38a-504(d)
Sec. 2	*January 1, 2020*	38a-542(d)
Sec. 3	*January 1, 2020*	38a-472g
Sec. 4	*January 1, 2020*	38a-482a
Sec. 5	*January 1, 2020*	38a-513c
Sec. 6	*January 1, 2020*	38a-478r